

Draft Rhode Island 2017 Alternative Payment Methodology Plan Recommended to Health Insurance Commissioner Kathleen C. Hittner December 16, 2015

The Alternative Payment Methodology Advisory Committee recommends that Health Insurance Commissioner Kathleen C. Hittner adopt the following Alternative Payment Methodology [\(APM\)](#) Plan for 2017.

I. Background and Purpose

This 2017 Alternative Payment Methodology Plan is adopted pursuant to Section 10(d)(2) of Regulation 2: Powers And Duties of the Office of the Health Insurance Commissioner, by Kathleen C. Hittner, Health Insurance Commissioner.

The purpose of Section 10(d)(2) of Regulation 2 is to “significantly reduce the use of fee-for-service payment as a payment methodology, in order to mitigate fee-for-service volume incentives which unreasonably and unnecessarily increase the overall cost of care, and to replace fee-for-service payment with alternative payment methodologies that provide incentives for better quality and more efficient delivery of health services.”¹

The APM Plan components, detailed below, are designed to provide incentives to move the Rhode Island marketplace away from the fee-for-service payment model and towards payment models that encourage high quality and lower cost of care.

II. Definitions from the 2016 Plan [with Recommended Changes](#)

(a) “Alternative Payment Methodology” means a payment methodology structured such that provider economic incentives, rather than focus on volume of services provided, focus upon:

- Improving quality of care; ~~and~~
- Improving population health; ~~and~~
- Reducing cost of care growth; ~~and~~
- Improving patient experience and engagement, and
- Improving access to care.

To qualify as an APM, the payment methodologies must define and evaluate cost performance relative to a “budget” that may be prospectively paid or retrospectively reconciled. Providers are rewarded for managing costs below the budget, should quality performance be acceptable, by retaining some or all of the savings. Providers may also be responsible for some or all of the costs that exceed the budget.

While generally not employing the aforementioned budget methodology, pay-for-performance payments and supplemental payments for patient-centered medical home functions paid to

¹ OHIC Regulation 2 Section 10(d)(2)(A)

PCPs or to ACOs will be included in the calculation of an insurer's APM target for calendar years ~~2016 and~~ 2017.

Relative to the 2016 plan, the definition of APMs is expanded for 2017 to include pay-for-performance payments and supplemental payments to specialists intended to provide incentives to improve communications and coordination among PCPs and specialists.

(b) "Approved Alternative Payment Methodologies" include:

- Total cost of care budget models;
- Limited scope of service budget models;
- Episode-based (bundled) payments;
- Infrastructure payments and pay-for-performance payments for 2016-2017, and
- Other non-fee-for-service payments that meet the definition (a) above as approved by OHIC.

(c) The Alternative Payment Methodology Plan specifies two targets for insurers to achieve.

(1) "Alternative Payment Methodology ~~(APM)~~ Target" means the aggregate use of APMs as a percentage of an insurer's annual commercial insured medical spend. The APM Target shall include:

- All fee-for-service payments under a population-based total cost of care contract with shared savings or shared risk;
- Episode-based (bundled) payments; primary care, specialty care or other limited scope-of-service capitation payments, and global capitation payments;
- Supplemental payments for infrastructure development and/or Care Manager services to patient-centered medical homes, specialist practices, and to accountable care organizations, and all pay-for-performance payments for ~~years 2016 and~~ 2017, and
- Shared savings distributions.

(2) "Non-Fee-for-Service (FFS) Target" means the use of strictly non-fee-for-service alternative payment methodology payments as a percentage of an insurer's annual commercial insured medical spend. The Non-FFS target defined in this subsection (2) is a subset of the APM Target defined in subsection (1), above. The Non-FFS Target shall include:

- Episode-based (bundled) payments, either prospectively paid or retrospectively reconciled, with a shared risk component;
- Limited scope-of-service capitation payments and global capitation payments;
- Quality payments that are associated with a non-fee-for-service payment (e.g., a quality payment on top of a bundled payment or PCP capitation);
- Shared savings distributions, and
- All supplemental payments for infrastructure development and/ or Care Manager services to patient-centered medical homes, specialist practices, and to accountable care organizations, for ~~years 2016 and~~ 2017.

III. Alternative Payment Methodology Targets

For purposes of meeting the “Alternative Payment Methodology Target” for calendar years 2017 and 2018, health insurers subject to the Affordability Standards shall take such actions as necessary to have 40% of insured medical payments made through an alternative payment methodology throughout the entirety of calendar year 2017 and 50% of insured medical payments made through an alternative payment methodology throughout the entirety of calendar year 2018.

For purposes of meeting the “Non-Fee-for-Service Target” for calendar years 2017 and 2018 health insurers subject to the Affordability Standards shall take such actions as necessary to have 6% of insured medical payments made through non-fee-for-service models for the entirety of calendar year 2017 and 10% of insured medical payments made through non-fee-for-service models for the entirety of calendar year 2018. The Committee shall may revisit the 2017 10% Non-Fee-for-Service Target in the fall of 2016 to confirm that it is an appropriate target.

IV. Identified Support for Value-Based Payment Reform

1. Specialist Engagement

Specialists play an important role within the health care system, influencing use of other expensive health care resources, particularly inpatient hospital services, outpatient procedures, imaging and testing. Primary care providers (PCPs) rely on specialists to treat more complex conditions than they are trained to care for; therefore specialists are important partners in implementing changes in payment models.

To ensure that specialists are engaged in initiatives to transform health care payment to support improved quality and increased efficiency through coordinated care, Rhode Island’s health insurers shall take such actions as necessary to develop programs with specialist providers that meet the following requirements.

Requirements:

1. Align incentives between PCPs and specialists to better coordinate care and improve the patient experience by improving communication among patients, PCPs and specialists⁷ and
2. Develop and implement alternative payment methodologies with high volume specialties and ~~or~~ high volume specialty care practices consistent with definitions under Section 2 above.

Consistent with the goals of the 2017 APM Plan, health insurers may implement financial incentives for specialists to participate in practice transformation. An example would be incentives to participate in the Rhode Island Quality Institute’s TCPI grant,

By June 1st, 2016 health insurers shall submit to OHIC, for approval by the Commissioner, a plan to carry out requirements 1 and 2 above. The plan should detail the specific programs and how they will advance the goals articulated in this 2017 APM plan.

~~Consistent with requirement 1 above, health insurers may also apply financial incentives for specialists to participate in practice transformation. An example would be RIQI's TCPI grant.~~

Finally, OHIC shall work with payers, providers, and consumers to develop publicly available measures of specialist cost and quality.

2. Consumer Safeguards

Consumers have an interest in high quality patient-centered care that is organized around the needs and goals of each patient. Consumer advocates have expressed concerns that some APMs may encourage providers to cherry-pick patients based on health status, skimp on care, and engage in other practices that impede access to high quality patient-centered care. In response to these concerns, the following insurer-provider contracting standards shall take effect.

A. Contracting Requirements:

1. All insurer contracts that transfer financial risk to medical service providers or ACOs shall include as part of the reimbursement model requirements that link performance on quality measures to reimbursement levels, such that medical service providers or ACOs will be penalized financially for poor quality performance and rewarded for high levels of quality performance. Quality measures should include at least one measure that assesses patient experience and/or access to referral services.

2. All insurer contracts that transfer financial risk to medical service providers or ACOs shall include clinical risk adjustment as part of the payment model.

B. OHIC Monitoring and Review of Information:

OHIC may collect and analyze financial and quality performance data that Rhode Island insurers or the state's All-Payer Claims Database generate or collect from medical service providers and ACOs, as well as member complaints regarding medical service providers and ACOs submitted to insurers and to OHIC.

OHIC may review any medical service provider or ACO contract to ensure compliance with the contracting requirements above.

3. Downside Risk

OHIC shall study options around setting a minimum downside risk threshold for medical service provider or ACO contracts. OHIC shall issue a report by June 1, 2016 detailing these options and open a 30-day public comment window. After public comment, the Commissioner may adopt standards in conjunction with the approval of insurer rate filings.

V. Conclusion

This 2017 Alternative Payment Methodology Plan is derived from the deliberations and draft recommendations of the Alternative Payment Methodology Committee. It advances progress towards the goals set forth in the OHIC Affordability Standards.

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